UnitedHealthcare®
A UnitedHealth Group Company

welcome

State of Tennessee
Your Health Benefit Information

UnitedHealthcare Services Company of the River Valley, Inc.
formerly John Deere Health Care, Inc.

Important Notice

This member handbook explains many features of the Health Maintenance Organization (HMO) option. It describes your benefits in general terms and is not intended to give all the details of every benefit, limitation, or exclusion. The Plan Document is the official legal publication that defines benefits. A copy is available for your review from your insurance preparer or from the State of Tennessee Division of Insurance Administrations web site at www.state.tn.us/finance/ins.

For services to be covered, they must be determined to be medically necessary.

If you are unsure about whether a procedure, type of facility, equipment, or any other expense is covered, ask your physician to submit a pre-determination request form to the claims administrator describing the condition and planned treatment. Pre-determination requests typically take up to three weeks to review.

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UNITEDHEALTHCARE SERVICE COMPANY OF THE RIVER VALLEY, INC.

State Group Insurance Program Participants

HMO Option

Welcome

At UnitedHealthcare, nothing is more important to us than providing quality health care services.

The plans we offer include preventive medicine benefits. We don't just provide benefits when you're sick, but we also offer you ways to help keep you and your family healthy. In addition, one of our top priorities is to provide you outstanding customer service. At UnitedHealthcare we put you, the member, first.

If you live or work in the following counties, you are eligible for the UnitedHealthcare HMO option.

Anderson
Bedford
Bledsoe
Blount
Bradley
Campbell
Cannon
Carter
Claiborne
Clay
Cocke
Coffee
Cumberland
Fentress
Franklin
Grainger
Greene
Grundy
Hamblen
Hamilton
Hancock
Hawkins
Jackson
Jefferson
Johnson
Knox
Lincoln
Loudon
Marion
Marshall
McMinn
Meigs
Monroe
Moore
Morgan
Overton
Pickett
Polk
Putnam
Rhea
Roane
Scott
Sequatchie
Sevier
Smith
Sullivan
Unicoi
Union
Van Buren
Warren
Washington
White

Visit our website at www.uhcrivervalley.com/employer/tennstate

Plan Administration and Claims Administration

The Division of Insurance Administration of the Department of Finance and Administration is the plan administrator and UnitedHealthcare Service Company of the River Valley, Inc. is the claims administrator. This program is administered using the benefit structure established by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund consisting of your premiums and the employer's contributions (if applicable) and not by an insurance company. UnitedHealthcare is contracted by the State to process claims, establish and maintain adequate provider networks, and conduct utilization management reviews.

Claims paid in error for any reason will be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting the Division of Insurance Administration.

Eligibility and Enrollment Topics
Please refer to your Insurance Handbook, available from your insurance preparer, for all information related to eligibility and enrollment. Eligibility and enrollment are managed by the plan administrator.

Customer Service
For information about specific health care claims, please call customer service. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting customer service, you will be asked to verify your identity and give information from your identification card.

Customer Service: **1-877-366-0011**, 8 a.m. - 5 p.m. (EST) M-F

TDD: **1-800-884-4327**

Pharmacy Orders: **1-800-273-3455**

Chiropractic network and claim inquiries: **1-800-274-7526**

New Generations (prenatal program): **1-800-369-2704, extension 51316**

Mailing address for claims:

UnitedHealthcare
3800 Avenue of the Cities, Suite 200
Moline, IL 61265

We also have local customer service offices for face-to-face inquires with office hours of 8:00 a.m. - 4:30 p.m., M-F (EST). Locations are:

Chattanooga:	7213 Noah Reid Road, Suite 102, Chattanooga, TN 37421
Kingsport:	2033 Meadowview Lane, Suite 300, Kingsport, TN 37660
Knoxville:	408 North Cedar Bluff Road, Suite 400, Knoxville, TN 37923

Web Site
Members can access benefit and provider information with a site specifically designed for state group insurance program participants. Point your web browser to **www.uhcrivervalley/ employer/tennstate/** to search for providers, view pharmacy information, and access other helpful information.

Mental Health and Substance Abuse
Mental health and substance abuse benefits are administered separately from your medical benefits. Please contact Magellan Health Services at 1-800-308-4934 for assistance in this area. See your agency insurance preparer for detailed benefit information.

Medical Benefits at a Glance

INPATIENT SERVICES	
Physician services	100% benefit
Hospital services (includes semi-private room and board, operating room, intensive care, x-ray, laboratory, drugs, supplies and physician services)	$100 copay per admission
OUTPATIENT SERVICES	
PCP office visit	$15 copay
Specialist office visit	$20 copay
X-ray, lab and diagnostics	100% benefit
Allergy injection by doctor	$15 copay PCP $20 copay specialist
Allergy injection by nurse/nurse practitioner	100% benefit
Home health care (125 visits per plan year)	$15 copay
Home infusion therapy	$15 copay
Surgical services – physician	$15 copay PCP $20 copay specialist
Surgical services – facility	100% benefit
Chiropractors	$15 copay
PREVENTIVE HEALTH/WELL CARE	
Well child checkup and immunizations	$15 copay PCP $20 copay specialist
Annual physical exam - Adult	$15 copay
Family planning	$15 copay PCP $20 copay specialist
Annual hearing and vision screening (see covered expenses)	$15 copay PCP $20 copay specialist
MATERNITY CARE	
Physician care	$15 copay; first visit only
Hospital care	$100 copay per admission
Midwives (in a licensed health care facility)	100% benefit
REHABILITATION AND THERAPY SERVICES	
Inpatient services	$100 copay
Outpatient services (subject to plan limits)	$15 copay
Skilled nursing facility (100 day limit following approved hospitalization)	100% benefit

EMERGENCY CARE (see page 15-16 for definition/guidelines)	
Emergency room services	$50 copay
URGENT CARE	
Received at a walk-in clinic	$15 copay
Received at a hospital emergency room	$50 copay
TRANSPORTATION	
Ambulance services (air and ground)	100% of reasonable charges
If approved for out-of-state exception (limits may apply)	100% of reasonable charges
If approved for transplant (limits may apply)	100% of reasonable charges
APPLIANCES AND EQUIPMENT	
Durable medical equipment	100% benefit
Supplies (ostomy, bandages, dressings, diabetic)	$5 copay (31-day supply)
HOSPICE CARE	
Through an approved program	100% benefit
PRESCRIPTION DRUGS	
Generic	$5 copay
Preferred or Formulary	$20 copay
Non-Preferred or Non-Formulary	$40 copay
Extended prescriptions available for one copay through the home delivery program and certain participating mail-at-retail pharmacies	
ROUTINE VISION CARE	
Optometrist	$15 copay
Ophthalmologist	$20 copay
Limited to one visit/year. For in-network benefits, exam must be obtained from a Davis Vision Provider and ID card must be presented.	

DENTISTS	
Extraction of impacted wisdom teeth, excision of solid based oral tumors, accidental injury, orthodontic treatment for correction of facial hemiatrophy or congenital birth defect (subject to plan limits)	100% of reasonable charge after $20 copay

Copays represent cost to participant; percentages represent portion paid by the plan.
Benefits will not be provided without the appropriate referrals.

Covered Medical Expenses

(1) Office visits to a physician or a specialist due to an injury or illness.

(2) Family planning and infertility services including history, physical examination, laboratory tests, advice, and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing, and treatment for organic impotence. If fertility services are initiated (including, but not limited to, artificial insemination and in-vitro fertilization), benefits will cease.

(3) Nutritional guidance when medically appropriate as determined by the claims administrator.

(4) Adult preventive care including one routine health assessment per plan year (age 18+), bone density scans (female age 50+ once per year or 65+ as medically necessary), routine women's health exam including breast exam, Pap smear for cervical cancer screening and pelvic exame (age 18+), cholesterol screening (age 40+) every five years or more often if medically necessary, and immunizations (tetanus, measles, mumps, rubella, pneumococcal, influenza, hepatitis B).

(5) Well-child visits to physicians including checkups and immunizations, 12 visits combined through age 5. Annual checkups for ages 6 - 17 and immunizations as recommended by the Centers for Disease Control and Prevention (CDC).

(6) Mammogram screenings within the following guidelines: Once as a baseline mammogram between ages 35-39; once every year for ages 40 and over; or when prescribed by a physician and determined to be medically necessary.

(7) Prostate screening annually for men who have been treated for prostate cancer with radiation, surgery, or chemotherapy and for men over the age of 45 who have enlarged prostates as determined by rectal examination. This annual testing is also covered for men of any age with prostate nodules or other irregularity noted upon rectal exam. The PSA test will be covered as the primary screening tool of men over age 50 and transrectal ultrasound will be covered in these individuals found to have elevated PSA levels.

(8) Hospital room and board and general nursing care in a semi-private room or in a specialty care unit if pre-authorized.

(9) Charges for medically necessary surgical procedures and administration of anesthesia.

(10) Charges for diagnostic laboratory and x-ray services.

(11) An approved hospice program that is designed to provide the terminally ill patient with more dignified, comfortable, and less costly care during the six months before death.

(12) Durable medical equipment (DME), consistent with a patient's diagnosis, recognized as

therapeutically effective and prescribed by a physician, and not meant to serve as a comfort or convenience item. Benefits are provided for either rental or purchase of equipment.

(13) Removal of impacted wisdom teeth, excision of solid-based oral tumors, and treatment of accidental injury (other than by eating or chewing) to sound natural teeth.

(14) Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for 28 days after surgery.

(15) The initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury and subsequent purchases due to physical growth for a covered dependent through age 18. One additional limb prosthesis past age 18 will be covered if additional surgery has altered the size or shape of the stump, or if a severe medical condition could result from improper fitting of the initial prosthesis. Replacement prosthetic due to normal wear and tear or physical development, with written approval.

(16) Smoking cessation aids requiring a prescription with a limit of one 90-day period per year and two 90-day periods per lifetime.

(17) Expenses for temporomandibular joint malfunctions (TMJ) including history, exams, and office visits; x-rays of the joint; diagnostic study casts; appliances (removable or fixed); physical medicine procedures such as surgery; and medications.

(18) Medically necessary services performed by a registered/licensed physical, occupational, or speech therapist limited to a maximum of 45 visits per condition, per plan year.

(19) The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery.

(20) Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus. Intrastromal Corneal Ring Segments (ICRS) for vision correction are also covered with a diagnosis of keratoconus when certain medical appropriateness criteria are met.

(21) Cosmetic surgery only when in connection with treatment of a congenital anomaly that severely impairs the function of a bodily organ or due to a traumatic injury or illness; or reconstructive breast surgery if needed following a covered mastectomy (but not a lumpectomy), as well as surgery to the non-diseased breast to establish symmetry.

(22) Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to $500 per calendar year. Coverage for additional training and education is available when determined to be medically necessary by the claims administrator.

(23) Insulin, the related syringes (including needle-free syringes when medically necessary as

determined by the claims administrator based on the patient's age, weight, skin, and medical condition, and/or the frequency of injections), home blood glucose monitors, and related supplies for the treatment of diabetes as approved by a physician.

(24) Screenings of the eyes (not including refractive services and supplies) and hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss when medically necessary. Availability of benefits limited to once per plan year.

(25) Certain organ and bone marrow transplant medical expenses and services (preauthorization required). Hotel and meal expenses will be paid at $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum benefit is $15,000 per transplant.

(26) Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, surgical collars, lumbosacral supports, corsets-back and special surgical, trusses, and rigid back or leg braces.

(27) Foot orthotics, including therapeutic shoes, if an integral part of a leg brace, depth or custom-molded, including inserts for those with diabetes mellitus and certain related complications, rehabilitative when part of post-surgical or post-traumatic casting care, prosthetic shoes that are an integral part of the prosthesis, and ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses. Such items will be covered when prescribed by a physician if medically necessary as determined by the claims administrator.

(28) Home health care when certified and approved as medically necessary by the claims administrator. When ordered by a physician, covered services are limited to intermittent skilled nursing care given or supervised by a registered nurse with up to 30 home health aide visits.

(29) Medically necessary ground and air ambulance services to and from the nearest general hospital or specialty hospital.

(30) Blood plasma or whole blood (including components and derivatives) unless donated or replaced by you or a family member.

(31) Ketogenic diet counseling when medically necessary and authorized through case management.

(32) Medically appropriate sleep studies and evaluations.

(33) Charges, including procedure charges, physician charges, and facility charges, for certain PET scans when determined to be medically necessary and approved by the claims administrator. (Members or physicians should verify medical necessity and benefit eligibility before incurring charges for use of the PET scan technology.)

(34) Some surgical weight reduction programs.

(35) Colorectal screenings. Beginning at age 50, men and women have one of the following five

screening options available: (1) yearly fecal occult blood test (FOBT), (2) flexible sigmoidoscopy every five years, (3) yearly fecal occult blood test and flexible sigmoidoscopy every five years (preferred over either test alone), (4) double contrast barium enema every five years, or (5) colonoscopy every five years. For individuals determined by their physician to be at high risk for colorectal cancer due to medical or family history, screening may need to begin at an earlier age and occur more frequently.

(36) Tubal ligation and vasectomy.

(37) Routine patient costs related to clinical trials as defined by TCA 56-7-2365.

Excluded Services and Procedures

(1) Services provided by a participant's immediate family member, whether by blood, marriage, or adoption.

(2) Services not ordered or furnished by an eligible provider.

(3) Charges in excess of the maximum allowable charge when using out-of-network providers.

(4) Experimental or investigational treatments, procedures, facilities, equipment, drugs, or supplies as initiallly determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency. (Members are held harmless for charges or services from network providers **unless** they have signed a waiver accepting responsibility for the cost.)

(5) Charges that would be considered a covered injury paid under workers' compensation, regardless of the presence or absence of workers' compensation coverage.

(6) Comfort or convenience items.

(7) Humidifiers, dehumidifiers, exercise devices, blood pressure kits, heating pads, sun or heat lamps.

(8) Podiatric items such as inner soles, corn plasters, foot padding, arch supports, routine foot care, or orthopedic shoes for correction of a deformity or abnormality of the musculoskeletal system unless one or both podiatric items are attached to a brace. Charges for removal of corns or calluses, or trimming of toenails, with the exception of a diagnosis of diabetes.

(9) Hearing aids, including examinations and fittings.

(10) Midwife services outside a licensed health care facility.

(11) Nonsurgical service for weight control or reduction, including prescription medication.

(12) Artificial or nonhuman organ transplants and related services, except for Ventricular Assist Devices (VAD) adn Total Artificial Hearts (TAH) when determined to be medically necessary by the claims administrator.

(13) Radial keratotomy, LASIK, or other procedures to correct refractive errors; eyeglasses, sunglasses, or contacts including examinations and fitting charges.

(14) Surgery or treatment for, or related to, psychogenic sexual dysfunction or transformation.

(15) Services or supplies in connection with artificial insemination, in-vitro fertilization, or any procedure intended to create a pregnancy.

(16) Wigs.

(17) Ear or body piercing.

(18) Custodial care, unapproved sitters, day and evening care centers (primarily for rest or for the elderly), or diapers.

(19) Programs considered primarily educational and materials such as books or tapes.

(20) Extraneous fees such as postage, shipping or mailing fees, service taxes, stat charges, or collection and handling fees. Charges for telephone consultations.

(21) Over-the-counter medications and supplies (except injectable B-12 for pernicious anemia).

(22) Hotel charges unless pre-approved through the organ transplant program.

(23) Cosmetic surgery and related expenses including, but not limited to, scar revision, rhinoplasty, and saline injection of varicose veins.

(24) Any dental care, treatment, or oral surgery relating to the teeth and gums including, but not limited to, dental appliances, dental prostheses (such as crowns, bridges, or dentures), implants, orthodontic care, fillings, extractions, endodontic care, treatment of caries, gingivitis, or periodontal disease.

(25) Treatment and therapies for maintenance purposes.

(26) Reversal of sterilization procedures.

(27) Charges for prescriptions that are lost, stolen, misplaced, or forgotten.

(28) Charges incurred outside the United States unless traveling for business or pleasure and an emergency arises.

(29) Charges for bathroom chairs, stools, and tub handrails.

(30) Fitness clubs and programs.

How the plan works

Choice of Doctors
Under the HMO, you are required to select and receive care from a primary care physician (PCP) in our network of providers. Each member of your family may choose a different physician to serve as their Primary Care Physician from the list. These physicians are internists, family practitioners, general practitioners, and pediatricians. Your PCP will provide your primary care and, when medically necessary, will refer you to other doctors or facilities for treatment. To receive coverage for such services, you must have a prior written or electronic referral from your PCP for all non-emergency services and any necessary follow-up.

In most cases, specialty services are available from network specialty providers. However, if the care you need is not available from a network provider, your PCP will request a preauthorized referral for you to see an out-of-network provider.

Referrals are case specific and the details will be included on your referral letter. Should you change your PCP, all referrals issued by your former PCP are void. Remind your new PCP that you will need a new referral for any necessary specialty care.

To change your PCP, please contact your local customer service office. The effective date of your change will depend on the following:

- If you change your PCP before the 20th day of any month (betweeen 1st and 20th), it will become effective the 1st day of the following month (example: a change requested on July 19 will become effective August 1).
- If you change your PCP after the 20th day of any month (between the 20th and last day of the month), it will become effective the 1st day of the subsequent month (example: a change requested on July 21 will become effective September 1).

OB/GYN Services
Once during each calendar year, you can receive a routine OB/GYN well-woman exam from a participating provider without a referral from your PCP. The yearly well-woman examination is limited to one breast exam, Pap smear and pelvic exam within the calendar year. If your doctor determines you should see another specialist or be admitted to the hospital, all prior authorization requirements will be handled by that physician.

New Generations
This program gives expectant mothers the information, education, and support they need to help reduce any health risks during this special time. Enrolling in New Generations can help you form the healthy habits that can greatly reduce complications in your pregnancy. Finding good prenatal care can help prevent many medical problems for you and your baby. New Generations will give you prenatal education, encourage you to participate in regular prenatal health care, and evaluate whether you need special support for a healthy pregnancy. Each mother-to-be who participates in the New Generations program will receive a free baby gift.

Urgent Care
Members sometimes have a need for medical care during evenings or on weekends. "Urgent care" is care that is important, but does not result from a life-threatening condition. Urgent care health problems are usually marked by rapid onset of persistent or unusual discomfort associated with an illness. If you need urgent care, contact your doctor. Many physicians' offices use an answering service after hours. When you call after regular hours, be prepared to describe your symptoms and leave a number where the doctor can call you back. Your doctor will offer advice and the best course of treatment for you.

Examples of urgent care situations are:

- Difficulty in breathing
- Prolonged nose bleed
- Short-term high fever
- Cuts requiring stitches

Emergency Care
If you have a medical emergency, seek treatment at the nearest medical facility. Contact your doctor or our customer service section within 24 hours if you are in the State of Tennessee or 48 hours if you are out-of-state. Your doctor will make arrangements for your follow-up care.

Use of the Emergency Room
The emergency room (ER) should be used only in the case of an emergency or in an urgent care situation when your doctor advises. The highest level of benefits is available for any emergency room visit that meets the following definition of an emergency.

An "emergency" is a medical condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy (or, with respect to pregnant women, the health of the woman or her unborn child)
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

The prudent layperson approach is designed to address the issue of the need for a member to seek prompt access to care when symptoms appear serious.

For each covered emergency room visit, you will pay the emergency room copayment unless admitted or if the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room. Should the ER require you to pay in full (not in-network), file the billing statement with our office and you will be reimbursed subject to the terms and conditions of the plan.

Hospitalization
If you need to be hospitalized, your doctor will make the necessary arrangements at a network facility and obtain prior authorization. If you are admitted to a hospital without our prior authorization, your benefits may be denied.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should notify your doctor of any urgent care hospitalization within 24 hours (48 hours if you are out-of-state) of your admission. You should also notify your physician of emergency admissions within the same timeframe. This allows your doctor to make necessary arrangements for any follow-up care. If you have seen a specialist and need to be admitted to a hospital, your specialist will refer you back to your PCP to coordinate your hospital care with our office. Maternity admissions do not require pre-authorization.

If you are readmitted within 48 hours of the initial visit for the same episode of an illness or injury, the required copayment will be waived.

Prior Authorization
Prior authorization is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with your medical needs of the member and with patterns of care of an established managed care environment for treatment of a particular illness, injury, or medical condition. Prior authorization is required for certain services including, but not limited to:

- Inpatient hospital services
- Skilled nursing facility stays
- Home health care
- Inpatient rehabilitation services

Certain drugs used for home infusion therapy also require prior authorization. All providers for the above services should request these authorizations prior to services being rendered, except in an emergency situation.

Coordination of Benefits with Other Insurance Plans
If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100 percent of allowable charges. At no time should reimbursement be more than 100 percent of actual expenses. If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document. Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g., active, retired, COBRA). If your spouse has coverage through his or her employer, and has you covered, then that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits. Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to our office.

Once a year you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments. The completed form letter must be received before any further claims processing can take place.

Claims Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third-party insurance company. This would include automobile or homeowner's insurance, whether yours or another's. You are required to assist in this process and should not settle any claim without written consent from our subrogation department.

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses incurred for emergency care are covered at the network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Urgent care services without an appropriate referral from your PCP or prior authorization will not be covered. There is no out-of-country benefit for routine care services. Claims from a non-English speaking country should be translated to standard English at the covered person's expense. Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

Benefit Level Exceptions

Two types of exceptions - unique care and continuous care - may be granted for which benefits will be paid at the network level to an out-of-network provider or facility. All requests for exceptions are reviewed individually by our office. *Exceptions will be granted only for medical necessity, not for convenience.* To apply for unique or continuous care exceptions, work with your provider to submit the following information in a letter to our office address, attention State of Tennessee Unique Care Coordinator. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all pertinent information can be gathered:

- Patient name and ID number.
- Name and type of provider you are requesting.
- Diagnosis and treatment plan, date(s) of service.
- Medical records/notes supporting request.
- A statement explaining why this treatment cannot be received at a network facility or provided by a network physician.

Unique Care Exceptions
A unique care exception can be granted for treatment not routinely available from a network provider in an employee's geographic area. This exceptions is based on the patient's condition or need for a particular physician and must be requested before receiving care. We will determine whether a network provider is available to provide treatment for the illness or injury.

If a unique care exception is granted, benefits are paid at the network level. Any charges above the maximum allowable are the patient's responsibility. If distance (out-of-state) traveling is required, reimbursement will be at 80 percent of commercial coach airfare or ground travel at the state approved mileage rate, if appropriate. When unique care exceptions are granted, a time frame for this approval is given. If the need for unique care is anticipated beyond the stated time frame, then another unique care request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required. The review of this request to extend a unique care approval will include an examination of the available network in an effort to determine if the required care can now be accessed within the network.

Continuous Care Exceptions
A continuous care exception can be granted when a patient is undergoing an active treatment plan for a serious medical condition, including pregnancy. This exception takes into account a patient's established relationship with an out-of-network provider. Our medical director will determine the time frame in which continuous care may be covered. Any charges above the maximum allowable are the patient's responsibility.

Case Management
Case management is a program that promotes quality and cost effective coordination of care for members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing to discuss or propose alternative treatment plans. Members may also contact customer service if they believe they would benefit from case management. In situations involving medical appropriateness, a case maanger may approve additional speech, occupational, and physical therapy visits beyond plan limits.

Filing Claims
Our office is responsible for all medical plan claims processing. When you visit a network doctor or facility, be sure and show your identification card. The provider will file your claim directly. These network providers must file your claim within six months of the date of service. All questions regarding claims should be addressed to customer service.

If you need to pay for care because of an emergency or urgent (non-routine) situation when traveling outside of our service area, send an itemized bill including the following information. Payment is subject to the terms and conditions set forth by the plan administrator.

- Member name and ID
- Daytime phone number
- Date of service and/or supplies provided
- State or country in which services were rendered or supplies obtained
- Description of services/supplies
- Provider's name, address, and tax identification number
- An interpretation of the claim, if in a foreign language
- Accident details (if applicable)

Disease Management Program

Disease management programs are developed internally in accordance with nationally recognized practice guidelines. Registered nurses with expertise in the specific disease state manage and implement the programs throughout the health plan. Members are identified for the programs through a monthly analysis of claims.

The programs provide interventions for members with chronic disease states as well as information and decision tools for physicians caring for those members. Written educational materials and a robust member website provide knowledge and support for members. Physicians receive a quarterly Care Management Tool with actionable data indicating their patients with asthma, diabetes and heart failure who are in need of review. Triggers for the quarterly report include missing lab tests, lab results outside target ranges, or inappropriate medication management for a specific disease state. All eligible members receive low-risk interventions.

Members with events such as hospitalizations, missing medications, missing tests, or those who are identified by a predictive model are considered moderate or high risk. When members meet moderate or high-risk criteria, they and their physicians receive additional interventions. These interventions may include additional contact via letters and reports, or telephonic outreach by nurse case managers.

Pharmacy Program

Three levels of benefits are available for prescription drugs, and your choice determines the copayment amount you pay each time you have your drugs dispensed by a participating network pharmacy.

- Generic drugs are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand-name medications, and are available in many instances.
- Formulary brand-names are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the formulary. This list includes many popular brand-name drugs.
- Non-formulary brands are in the third tier and will cost you the highest copayment.

Limitations
Prescriptions may be filled for the quantity specified by your physician for a single course of treatment up to a 34-day supply at retail or, if appropriate, up to a 100-day supply through the home delivery program and certain participating mail-at-retail pharmacies.

Certain drugs may have prior authorization requirements or specific quantity limits. These drugs cannot be dispensed by the pharmacist in an amount greater than the specified limit or where prior authorization has not been obtained by your physician. You should talk to your doctor if you encounter problems with the quantity limits or prior authorization requirements of the pharmacy program.

Exclusions
Some types of medications are not covered by your plan. An exclusion does not mean you cannot have a particular drug; it simply means that no benefits will be provided and you will be responsible for the total cost of the drug.

Filling a Prescription at a Retail Pharmacy
Visit a participating network pharmacy and show your ID card when you purchase your prescription. Pay the appropriate copayment for the prescription at that time and your network pharmacist will electronically file your claim. If filling an extended-duration prescription at retail, be sure to use a participating mail-at-retail provider.

If you have a prescription need when outside the plan's service area, you should try to use a pharmacy in the plan's national pharmacy network. This is list is available in your provider directory and our Web site. However, you may not have access to a participating pharmacy in an emergency or urgent care situation, or if you are traveling outside of the plan's service area. If you must have a prescription filled in such a situation, coverage is limited to items connected to covered emergency or out-of-area urgent care services. You must pay the pharmacy directly for the cost of the prescription. You are

responsible for submitting a written request for reimbursement to our office, accompanied by the receipt for the prescription. We will review your request and determine whether the event meets the qualifications for reimbursement. If approved, you will be reimbursed for the cost minus any applicable copayment.

If you are planning a trip and need to purchase medications ahead of time, your physician's office can call 1-877-366-0011, option 2, to request an early refill override.

Filling a Prescription Using the Home Delivery Program

To begin using the home delivery program, follow these steps:

- Obtain a written prescription from your doctor for up to a 100-day supply of your medication, with three refills, if appropriate.
- Be sure your name, address, and phone number, as well as your doctor's name, address, and phone number, are clearly printed on each prescription.
- Complete a mail order service form. A copy is enclosed in the back of this handbook.
- Send the order form, along with your prescription, to the address at the bottom of the form. Be sure to include your credit card information for your copayment or send a personal check or money order. If you have questions about the amount to include, contact the prescription home delivery service line.
- You will receive your medication, along with written information about your medication, within 14 days from the time you mail your order.

Once you have started using the benefits of the home delivery service, you can order medication refills via email to wmsrx@wal-mart.com or by phone at 1-800-273-3455 (M-F: 7 a.m. - 7 p.m., Sat: 8 a.m. - noon CST). You will need to provide your prescription number, member ID number and credit card information.

Member Rights and Responsibilities

Member Rights

You have the right to:

- Be treated with respect and dignity.
- Expect that any information you give will be treated in a confidential manner.
- Information about policies and services of the plan.
- Information regarding network providers.
- Medically necessary and appropriate medical care.
- Information about your health.
- Make decisions about your health care with practitioners.
- Voice complaints about your health care providers, the care given to you, or the HMO plan. You can expect an answer within a reasonable time. You also have the right to formally appeal this answer if you do not agree.
- A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage.

Confidentiality/Privacy

UnitedHealthcare understands that your health is your own private business. We can assure you that we will treat your medical and claim records and information in a confidential manner.

UnitedHealthcare respects your privacy and is required by federal law to comply with the Health Insurance Portability and Accountability Act and Privacy regulations (45 C.F.R. Parts 160-164, collectively "HIPAA"). HIPAA allows for use and disclosure of your protected health information for health care operations and payment without your prior written consent. The following is a list of some of the allowed purposes, but is not an all inclusive list:

- Claim processing.
- Performing peer review, utilization review, and medical audits.
- Administration of any programs established by us for quality health care and control of health care costs.

UnitedHealthcare has taken important steps to protect your privacy:

- Our employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out our established policies.
- Employees only have access to information needed to perform their job functions.
- Your oral, written, and electronic information is protected through data system security features and through established policies and procedures.
- Our contracted practitioners and providers follow state and federal confidentiality and privacy laws and regulations. They are committed to protecting your medical information.
- UnitedHealthcare Suppliers must sign Business Associate Agreements if they receive personal health information for purposes of plan administration, such as use of measurement data to improve quality.
- It is our policy not to release member specific health information to employers unless allowed by law.

You also have rights related to the privacy of your health care information:

- You have the right to approve the release of personal health information in special circumstances.
- You have a right to request authorization for another individual to access your health care information who, under law, does not already have authorization to access the information.
- You have the right to access your claim records received by UnitedHealthcare from health care providers.
- You have the right to request restrictions on your health care information.

You can take comfort in knowing that privacy is important to us. We encourage you to call one of our customer service representatives if you have questions about our privacy policies and practices.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any stage of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurances as other services and pre-existing waiting periods apply, if applicable.

Member Responsibilities

Members are responsible for:

- Reading the member materials in their entirety and complying with the rules and limitations as stated.
- Contacting in-network primary care providers to arrange for medical appointments as necessary.
- Notifying in-network providers in a timely manner of any cancellations of appointments.
- Paying the coinsurances and deductibles as stated in the benefit plan documents at the time service is provided.
- Receiving a pre-authorized referral for services, when required, and complying with the limits of the pre-authorized referral.
- Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.
- Using in-network providers consistent with the applicable benefit plan.
- Providing, to the extent possible, information needed by professional staff in order to care for the member.
- Following instructions and guidelines given by those providing health care services.

Appeal Procedures
If you experience a problem relating to the plan policies or the services provided, there are established procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

Administrative Appeal
To file an appeal regarding an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues, or timely filing issues) contact your agency or workplace insurance preparer immediately.

Mental Health and Substance Abuse Appeals
Contact Magellan Health Services at 1-800-308-4934 for EAP, mental health, and substance abuse appeals.

Appealing to the Claims Administrator
If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call customer service to discuss the issue. If the issue cannot be resolved through customer service, you may file a formal request for review or member grievance by completing the appropriate form and returning it within the specified time frame. When your completed form is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. When a determination is made, you will be notified in writing and advised of any further appeal options.

If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., because the member cannot afford to pay for such services), then providers may request an expedited reconsideration. If the treating provider fails to request the reconsideration and decides not to provide urgently needed services, then the member, or someone acting on the member's behalf, may request the expedited reconsideration. If we agree that it is appropriate to conduct an expedited reconsideration, we will inform the member of our decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

Please Note: The expedited reconsideration process is only applicable in situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the medical situation is perceived to be life threatening.

Appealing to the Plan Administrator
The State of Tennessee, Division of Insurance Administration has an appeal process that is available to you AFTER you have exhausted the grievance process with the claims administrator. Appeals must

be requested in writing within two years of the claim determination or decision. To file an appeal at the state level, the member should send a letter and supporting documentation (e.g., explanation of benefit statements, decision letters, statements from healthcare providers, and medical records) to:

Appeals Coordinator, Division of Insurance Administration
13th Floor, Wm. R. Snodgrass Tennessee Tower
312 Eighth Avenue North
Nashville, TN 37243

It is a good idea to maintain a copy of all correspondence you send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 615-741-3590 or 1-800-253-9981.

The appeals coordinator in the Division of Insurance Administration will thoroughly review all information submitted to determine the exact nature of the appeal. The majority of requests for appeal require additional review by the claims administrator. The average review takes approximately 60 days to complete. Some cases may require additional time for review depending on individual circumstances. Some cases may also require review by the state's independent medical consultant.

If consideration of your appeal does not result in a satisfactory resolution, the appeals coordinator may schedule it for additional review by the Insurance Appeals Staff Review Committee. When this occurs, the member will have the option of attending the committee meeting, or the appeal can be reviewed based on the written record. The Staff Review Committee will hear the appeal and their recommendation will be reported to the Appeals Subcommittee. The subcommittee will respond to the appeals coordinator within two weeks to indicate whether they agree with the Staff Review Committee's recommendation or vote to review the appeal at a second meeting. If the subcommittee agrees with the recommendation of the Staff Review Committee, the decision will stand. Members will be notified in writing as to whether or not requests are approved or denied by the committee. For denial decisions, the notification letter will explain any additional appeal options.

Some Questions & Answers

Q Do I need to select a physician when I enroll in coverage?
A Yes. You must select a PCP before you can enroll in coverage. Benefits will not be paid if you receive care and have not chosen a PCP.

Q Why is my PCP so important?
A Your PCP will be responsible for taking care of most of your medical needs and should be your first contact (24 hours a day, 7 days a week). He or she will help you maintain good health through periodic health evaluations and preventive health services.

Q What if I need to see a specialist for medical care my PCP cannot provide?
A If you need special medical care your PCP cannot provide, you will be referred to a specialist. Orthopedic surgeons, allergists, cardiologists and general surgeons are examples of specialists. This also applies to services such as physical therapy, home health care, and durable medical equipment. Your PCP will provide or arrange for all of your medical care and will make necessary referrals for you.

Q What if my physician is out of the office?
A Physicians "cover" for each other on a rotating schedule. This means there may be times when you will not be able to speak with your physician. The nurse or physician on call will be able to help you.

Q What if I must reach my physician after regular office hours?
A Most physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk to a representative from the answering service. The on-call health care professional will request some identifying information and will need a general description of your urgent medical need.

Q How does the plan work for those who live outside of Tennessee?
A This plan is only available to you if you live and/or work in the service area.

Q Is my child, who is attending college out of the service area, covered at the network level?
A Children attending college out of the service area are covered only for a medical emergency. Routine care is not covered outside of the service area.

Q Do I have a choice of hospitals?
A We have contracted with certain hospitals to provide care to you. If specialty care is not available at the contracted hospital(s), arrangements will be made to the appropriate non-network hospital.

Q What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?

A A provider appeals process is available for this situation.

Q How are the lists of prescriptions requiring prior approval and prescriptions with quantity limitations determined and how can they be changed?

A These lists are developed and maintained by a committee. The lists are established annually and reviewed quarterly and contain medications that are clinically effective as well as cost effective. A member or provider may suggest changes to these lists by contacting our office. Suggestions will receive a written response.